NEW JERSEY HUMAN SERVICES

Behavioral Health Integration Advisory Hub Meeting

July 23, 2025

10-11:30 AM EST

Please update your name on Zoom to include your name and organization. Thank you!

Housekeeping

All attendees will enter the meeting on mute

To use the “Chat” function, click the speech bubble icon at the bottom of the screen

Use the “raise hand” function if you wish to speak

You can enable closed captions at the bottom of the screen

Phase 1 of BH Integration went live January 1, 2025 as part of a phased approach to integrate BH services into managed care

Jan 1, 2025

Phase 1

Outpatient BH Services
(for both adults and children)

- MH outpatient counseling / psychotherapy
- MH partial hospitalization
- MH partial care in outpatient clinic
- MH outpatient hospital or clinic services
- SUD outpatient counseling
- SUD intensive outpatient
- SUD outpatient clinic
  - Ambulatory withdrawal management
  - Peer support services
  - SUD care management
- SUD partial care

TBD – new timeline to be communicated in upcoming months[1]

Phase 2

Residential & Opioid Treatment Programs

- Adult mental health rehab (AMHR) / MH supervised residential
- SUD short-term residential
- SUD — medically monitored inpatient withdrawal management
- SUD long-term residential
- Opioid treatment programs (OTPs)

TBD[1]

Phase 3

Additional BH services
TBD

- Opioid Overdose Recovery Programs (OORPs)
- Psychiatric Emergency Screening Services (PESS)
- Behavioral Health Homes (BHHs)
- Community Support Services (CSS)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted case management (TCM):
  - Program of Assertive Community Treatment (PACT)
  - Children's System of Care (CSOC)
  - Intensive Case Management Services (ICMS)

1. Scope and timing of Phase 2 and 3 to be determined after Phase 1 go-live based on additional analysis and stakeholder input

Today's Agenda

1. Remarks on federal policy changes
2. Phase 2 update
3. Phase 1 transition period extension and MCO readiness metrics
4. Quality reporting overview
5. Stakeholder resources and upcoming meetings

Remarks on federal policy changes

Key Medicaid provisions from H.R. 1 federal reconciliation bill

Eligibility changes

- ☆ Mandatory community engagement requirements (work requirements)
- ☆ Increased frequency of eligibility checks
  - Changes to retroactive Medicaid/CHIP eligibility
  - Elimination of Medicaid eligibility for many categories of documented immigrants

Financing changes

- ☆ Restrictions on provider taxes
  - Restrictions on State-Directed Payments
  - Reduced federal financing for “emergency Medicaid”
  - Mandatory federal recoupment of funding flagged by audits
  - Stricter “budget neutrality” requirements for 1115 demonstrations

Other changes

- ☆ Mandatory cost-sharing (co-pays) for certain members
  - Prohibits federal Medicaid funding for Planned Parenthood

☆ Deep-dive on specific provisions follows

Summary of key (projected) New Jersey impacts

Enrollment Impacts

- Up to **350,000 individuals** at risk of losing coverage due to work requirements and more frequent eligibility checks
- Estimated **15,000-25,000 individuals** lose coverage due to more restrictive immigration eligibility criteria

State Financial Impacts

- Loss of estimated **$400 million** generated annually by HMO assessment
- Loss of approximately **$45 million** due to reduced federal support for emergency Medicaid
- Need for **large investments in new eligibility systems and resources**

Provider Financial Impacts

- Hospitals' loss of **$2.8 billion** annually due to restrictions on provider taxes and directed payments
- Additional losses (likely billions in total) across the healthcare system, due to lower NJ FamilyCare enrollment

Other Impacts

- Potential **reduced utilization of services** due to new cost-sharing requirements
- Potential **loss of access** to **services** provided by Planned Parenthood
- Significantly **increased member burden** to prove eligibility
- Increased **eligibility workload** and **reduced County Option revenue** for county governments

Key Medicaid provisions that will likely impact behavioral health (BH)

	Work requirements	Eligibility re-determinations	Provider taxes	Mandatory cost-sharing (co-pays)
Overview	• Expansion adults must engage in 80 hours/month of work/related activities • Mandatory exemptions exist for individuals considered medically frail[1] and in certain SUD programs	• Medicaid agencies must redetermine eligibility for ACA expansion adults every 6 months, with most needing to verify work requirements at least every 6 months	• Prohibits new or increased provider taxes tied to federal Medicaid matching fund • Gradually lowers the cap on most existing provider taxes	• States must impose cost-sharing for most services for ACA expansion enrollees with incomes between 100-138% of federal policy level
Timeline	By Dec 2026	By Dec 2026	Effective 2025, with 3.5% limit by Oct 2031[2]	Effective Oct 2028
Likely BH impacts	• Exempt individuals may face increased admin burden from verifying exemption status • Unexempt individuals risk coverage loss and reporting burden (e.g., awaiting SUD treatment) • BH providers may face increased admin burden and declining patient revenue	• Increased BH coverage disruptions due to inability to prove eligibility 2x/year • More frequent gaps in access to care (e.g., medications) and increased admin burden for members • BH providers may face declining patient revenue due to coverage loss	• Significant amount of federal funding tied to provider taxes will be at-risk • Further pressure on BH provider rates	• BH services (mental health and SUD) are exempt from cost-sharing, with no copays required for members receiving these services *BH services are exempt*

1. Likely includes individuals with serious mental illness, substance use disorder, and intellectual or developmental disabilities 2. In expansion states, reduces current 6% provider tax limit 0.5% annually starting 10/1/2027 until it reaches new 3.5% limit by 10/1/2031; exempts intermediate care and nursing home facilities and bans new provider taxes from date bill was signed (7/4/2025)

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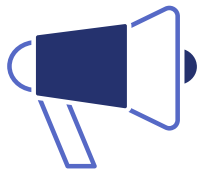
Phase 2 update



DMAHS will not integrate Phase 2 services on January 1, 2026

Given the Phase 1 transition period extension, the State is **delaying Phase 2 go-live to a later date** and will communicate a new timeline soon. The State will ensure providers, members, and MCOs have **ample time to prepare** and remain **actively engaged in planning for Phase 2**

Services planned for Phase 2

- Adult mental health rehabilitation / mental health supervised residential services
- SUD medically monitored inpatient withdrawal management
- SUD short-term residential
- SUD long-term residential
- Opioid treatment programs (OTPs)

Phase 1 transition period extension and MCO readiness metrics

DMAHS has extended some transition period flexibilities past June 30, 2025

In response to provider concerns and to minimize any risk of disruption of access to care, DMAHS is **temporarily extending some transition period flexibilities**. These modified transition period policies will be in effect **until at least October 31, 2025**.

Beginning July 1, 2025:
• Providers must submit prior authorization (PA) requests   • However, **PAs must be automatically approved and will not be denied for medical necessity** • Claims for PA-required services will be denied if no PA is on file

• MCOs have chosen to continue to pay out-of-network providers using Medicaid FFS rates until October 31st
• These claims must:
  • Be submitted with **no errors**
  • Have a **PA on file for a PA-required service** (*out-of-network PA requirements vary by MCO*)

DMAHS will continue to **assess each MCO's readiness** to determine an **end date for their transition period policies**

Prior authorization requirements for Phase 1 services

✓ - PA required for service

	Aetna		Fidelis Care		Horizon NJ Health		UnitedHealthcare		Wellpoint	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network[1]	In-network	Out-of-network	In-network	Out-of-network
MH / SUD partial care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MH partial hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SUD intensive outpatient	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SUD ambulatory withdrawal management	✓	✓	✓	✓		✓	✓	✓	✓	✓
MH / SUD outpatient counselling and psychotherapy		✓		✓						

Claims will be denied for providers who **do not follow these requirements**

1. For Horizon: Out-of-network providers who use the HF and UC modifiers or are a nurse psychiatry, psychiatry, child psychiatry, or neurology specialty type do not need to submit PAs for evaluation and management (E&M) service codes; all other out-of-network providers (e.g., primary care physicians) must submit a PA for these E&M codes

During the extended transition, DMAHS will use metrics to inform end of transition period decision making

Building block	Metric summary
Prior Authorizations	Reviewing claims denied for lack of PA on file, hypothetical PA request determinations, and outreach and education to providers with higher levels of PA denials
Claims	Reviewing information on the lifecycles of claims being processed for Phase 1 BH services and the volume of provider complaints and escalations
Network	Monitoring the volume of members served out-of-network and the presence of continuity of care plans for members who are at-risk for losing access to care

Note: Metrics subject to change

While transition flexibilities are extended, it is still important for providers to join MCO networks...

We encourage providers to **credential and contract with all 5 MCOs**

All MCOs are required to process complete credentialing applications **within 60 days of submission**

Note: *If you are an out-of-network (OON) provider, reimbursement and PA requirements may vary by MCO. You are encouraged to coordinate with each MCO to understand specific expectations*

…and submit high-quality PA requests

MCOs are holding **weekly office hours in July** to field PA inquiries and help providers submit PAs in line with MCO and State guidelines to ensure readiness for the end of the transition period auto-approval policy

Providers are encouraged to **join these sessions** and **outreach to MCO representatives** with any questions on PA processes and standards

We are also partnering with MCOs to ensure providers **receive meaningful feedback** on their PA submissions. To make this effective, it is **important for providers to action on this feedback**

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For discussion | Provider feedback

Have you attended any MCO PA-focused office hours? If so, how were the sessions?

How have MCOs provided feedback on changes needed to PAs to meet MCO standards? How can this process and related correspondence be improved?

What else can MCOs / the State be doing during the extended transition period to support providers and ensure readiness?

Please respond in the chat or raise your hand to share!

Member and advocate priorities during transition period extension

Key priorities for this period include…

- Reaching out to behavioral health providers to see if they participate in a member's network
- Joining MCO BH Care Management to help members get the care they need, when and where they need it, by working with different providers and services

For discussion | NJ FamilyCare member and member advocate feedback

What experiences have members had with accessing services or MCO integrated care management?

What feedback do you have on how the State and MCOs will support members who have providers that are currently out-of-network?

Please respond in the chat or raise your hand to share!

Quality reporting overview

New BH integration annual quality report is a part of NJ's overarching quality strategy

Recall: DMAHS has an overarching quality strategy

Current NJ quality strategy articulates priorities for physical & behavioral health

State activities for quality strategy include:

- Setting strategy
- Defining standards
- Establishing data collection methods / monitoring
- Enforcing requirements

MCO requirements include:

- Report on quality and performance (e.g., HEDIS, CAHPS)
- Annual Quality Assessment and Performance Improvement (QAPI) plan submitted to DMAHS

As part of BH integration, DMAHS requiring MCOs to submit new annual BH integration quality report

- Member satisfaction with…
  - Provider access
  - Timeliness of care
  - Quality of care
- Provider satisfaction with...
  - Network mgmt. & enrollment
  - Utilization management
  - Payment
  - Appeals process
  - Access to training/resources for cultural competency and responsiveness
- Quality and outcomes
- Disparities in care across member satisfaction and quality/outcomes

Source: NJ_DMAHS_Quality_Strategy_2022.pdf

Annual quality report will be used to track MCO performance on BH integration goals and identify opportunities to improve program design

Overview

Each MCO required to submit annual report and presentation on BH integration performance over past year and plans for year ahead

DMAHS has developed detailed guidance and data collection / report template to standardize reporting

MCO BH Quality Supervisor to provide overall ownership of report

Quantitative components

1. Summary of key BH integration MCO operational performance reports (e.g., credentialing, prior auth, CM, claims)
2. Member satisfaction survey results[1] ☆
3. Provider satisfaction survey results[2]
4. Quality & outcome measures
5. Disparities in care across member satisfaction/outcomes

Qualitative components

1. Narrative summary of performance for past year and goals for year ahead
2. MCO's strategic plan to address performance gaps

☆ Deep-dive follows

1. MCOs will be required to use a standard, nationally-recognized CAHPS survey to measure BH member satisfaction. 2. The state will centrally administer a standardized, state-designed survey to measure BH provider satisfaction across MCOs. MCOs will be responsible for circulating the survey to in-network providers

Quality measures | Specific quality metrics will be used to measure the success of the BH integration

Non-exhaustive

BH Quality Metric	Description
Diagnosed mental health disorders	% of members 3 years of age and older who had at least one diagnosed mental health disorder in the measurement year
Acute hospital utilization among members with BH diagnosis	% of members ages 18-64 who had an acute inpatient or observation stay followed by an unplanned acute readmission for any diagnosis within 30 days during measurement period
Emergency department utilization among members with BH diagnosis	% of members 18 years of age and older who had an ED visit in the measurement period
BH services and primary care	% of members who have not had a primary care visit in the year preceding an encounter with BH services; yet had an encounter with a physical health provider within 30 days after an encounter with BH services
Primary dental care for members with SUD	% of members with SUD diagnosis who had a primary dentist appointment within the calendar year
Controlling high blood pressure for members with BH diagnosis	% of members with BH diagnosis 18 years of age and older who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was treated during the measurement year

Note: DMAHS will also monitor several behavioral health HEDIS measures

Provider and member satisfaction | How providers and members can participate in the reporting activities

Providers

Provide critical feedback through the online provider satisfaction survey, with only one submission needed even if you participate in multiple MCOs, including

- Network management and enrollment
- Utilization management
- Payment
- Appeals
- Training / resources on cultural competency and responsiveness

Members

Provide critical feedback through the online member satisfaction survey provided by your MCO(s), including

- Provider access
- Timeliness of care
- Quality of care

Provider satisfaction | MCOs to use state designed survey to measure provider satisfaction

Network and enrollment

Overall satisfaction with MCO's credentialing, contracting, and Provider relations/services?

Utilization management

Overall satisfaction with the MCO's UM process?

Check if there are concerns

- ❑ Support from UM staff
- ❑ Prior authorization timeliness
- ❑ Clarity of reason for denial
- ❑ Peer-to-peer review
- ❑ Ease of mental health PA submission process
- ❑ Ease of substance use PA submission process

Payment

Overall satisfaction with how MCO processes claims?

Check if there are concerns

- ❑ Timeliness of initial claims processing
- ❑ Accuracy of payments
- ❑ Resolution of claims disputes/issues
- ❑ Unclear denial reason

Appeals

Overall satisfaction with the appeals process (if you have used it)?

Check if there are concerns

- ❑ Timeliness of appeals
- ❑ Adverse determination reason clarity

Training and resources

Overall satisfaction with the training and resources provided by the MCO?

Check if there are concerns

- ❑ Provider resources on MCO website
- ❑ Provider orientation / onboarding materials
- ❑ Provider materials
- ❑ Cultural sensitivity materials / sessions
- ❑ MCO language assistance
- ❑ MCO systems and portals
- ❑ Customer service

Stakeholder resources and upcoming meetings

Provider resources

BH Integration Stakeholder Information website[1]

The BHI stakeholder website has the following materials for providers and additional resources:

- Provider guidance packet – updated!
- Prior DMAHS training materials and recordings
- Behavioral Health Integration Overview and FAQ Pamphlet
- Provider Phase 1 Implementation FAQs

Member's Managed Care Organization

For specific member inquiries and MCO-related questions, please contact the member's MCO:

Aetna **Fidelis Care** **Horizon**

United **Wellpoint**

Refer to key MCO points of contact here or also in the provider guidance packet

DMAHS – Office of Managed Health Care

If your issue is related to **contracting & credentialing**, **claims & reimbursement**, **appeals,** or **prior authorizations**, then contact **OMHC**:

mahs.provider-inquiries@dhs.nj.gov

- Include specific details regarding your claims
- If multiple claims are impacted, the information should be summarized using an Excel file
- All Protected Health Information (PHI) must be sent securely

DMAHS Behavioral Health Unit

If your issue is related to **policies & guidelines**, **access to services**, or **general questions**, then contact DMAHS **BH Unit**:

dmahs.behavioralhealth@dhs.nj.gov

1-609-281-8028

1. https://www.nj.gov/humanservices/dmhas/information/stakeholder/

Member, caregiver, and family member resources

BH Integration Stakeholder Information website[1]

The BHI stakeholder website has the following materials for members and additional resources:

- December 2024 Member Meeting materials
  - Meeting presentation
  - Recording
- Member Care Management FAQ
- Behavioral Health Integration One-pager
- Behavioral Health Integration FAQ (in English and Spanish)
- NJ FamilyCare Behavioral Health Services One-pager

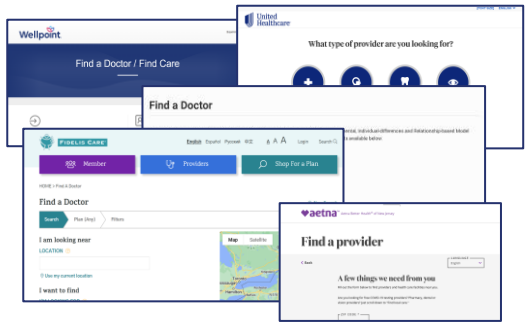
Medicaid Managed Care Member Handbooks

Detailed information regarding MCO Medicaid Plan; MCOs in process of updating

Aetna
Fidelis Care
Horizon
UnitedHealthcare
Wellpoint

Managed Care Organization Provider Directories

Where members and families can find "in-network" behavioral health providers



Aetna
Fidelis Care
Horizon
UnitedHealthcare
Wellpoint

State and MCO contact information for members

- **DMAHS BH Integration Unit**
  - 1-609-281-8028
  - Dmahs.behavioralhealth@dhs.nj.gov
- **Aetna**
  - 1-855-232-3596 (TTY: 711)
  - Member Portal
- **Fidelis Care**
  - 1-888-343-3547 (TTY: 711)
  - Member Portal
- **Horizon**
  - 1-800-682-9090 (TTY: 711)
  - Member Portal
- **UnitedHealthcare**
  - 1-800-941-4647 (TTY: 711)
  - Member Portal
- **Wellpoint**
  - 1-833-731-2147 (TTY: 711)
  - Member Portal

1. https://www.nj.gov/humanservices/dmhas/information/stakeholder /

Upcoming stakeholder engagement activities

Providers

Sept 11: DMHAS Quarterly Provider meeting

Ongoing: MCO provider prior authorization trainings

- Aetna: 7/24 from 4-4:50pm, 7/29 from 1:30-2:20pm
- Fidelis Care: 7/30 from 2-3pm *(weekly on Wednesdays through December)*
- Horizon: 7/30, 9/10, and 10/8 from 11am-12pm
- United: 7/22 from 12-1pm, 7/29 from 10-11am
- Wellpoint: 7/23 and 7/30 from 11am-12pm

Members

Aug-Dec: Monthly Consumer / Advocacy Organization Forums, next session on 8/1 (11am-12pm)

Ongoing: Stakeholder presentations

Cross-stakeholder

Sept: Advisory Hub meeting

Oct 30 (10am-12pm): Medical Assistance Advisory Council meeting

Thank you!